Exhibit 7

Aetna
SIU
PO Box 14079
Lexington, KY 40512-4079
Phone: 609-584-8518 / Fax: 860-975-1769
QBC601AA 0121 02 01 20

Category code: SIUA

11-9-2011

DCN# 111109070029

[redacted]

Member ID: W109077987

Dear Mr. [redacted]

We are conducting a review of charges for services submitted to Aetna. Please review the submitted charges below, and verify if the services were provided as listed by indicating "Yes" or "No". We also request that you respond to the questions on the next page of this letter. We are enclosing a self-addressed stamped envelope for your convenience in returning all pages of this letter. Please sign and date your response.

Note: This inquiry is to be completed by the patient/patient's guardian/representative. Please answer to the best of your ability without consulting the doctor, clinic, hospital or billing agent.

Patient: [redacted]				
Provider	**Service**	**Service Dates**	**Submitted Expenses**	**Y / N**
Humble Surgical Hospital	Medical Treatment	07/07/2011	$133,028.00	Yes ✓ No

(AFTER THE TREATMENT)

Please return all pages of this letter in the enclosed envelope. If you have any questions, please contact me at 1-609-584-8518. Thank you for your cooperation.

Please have the patient sign and return the attached Authorization for release of information with this letter. The authorization will be used to obtain medical records from the provider.

Sincerely,

Garrett Shohan

Garrett Shohan
Sr. Investigator
CASE 34047

NOTICE TO ALL PARTIES COMPLETING THIS FORM: This verification is needed in support of claim submissions made to us. It is fraudulent to intentionally fill out this form with information you know to be false or to omit important facts.

DCN: 111123089271 SEQ: 1123110049 LX

A016623

DCN# 111109070029

[redacted] 11-9-2011

OBC601AA 0121 02 01B 20
Category code: SIUA

Aetna

Authorization for Release of Information

Please read and sign the following Authorization to Release Information.

To: Humble Surgical Hospital

For claim evaluation purposes, I hereby authorize the above referenced provider of medical or dental services to release to Aetna and its authorized representatives any medical, dental, or hospital records (including that related to mental illness and/or AIDS/ARC/HIV).

I also specifically authorize the redisclosure of such information by Aetna for purposes related to claim evaluation, including claim verification or review by any reinsurer or any other insurer providing coverage with respect to the claim. I understand that, except as otherwise permitted or required by law, no other use or transfer of the information may be made without first obtaining my additional written consent on a form stating the need for the proposed new use or transfer to another person or entity.

I also understand that I may revoke this authorization at any time, except to the extent that action has been taken or information released, prior to the revocation. Otherwise, this authorization shall remain valid.

I know that I (or my authorized representative) have a right to request a copy of this authorization. A photocopy of this authorization will be as valid as the original.

[redacted] 11-17-11

Patient's or Authorized Person's Signature — Date

Relationship to Patient

DCN: 111123089271 SEQ: 1123110049 LX

DCN# 111109070029

[redacted] 11-9-2011

OBC601AA 0121 02 02 20
Category code: SIUA

1. Did you receive treatment(s) on the date(s) indicated on the previous page?
   Yes ✓
   No ____; if no, please explain.
   Comments: Services By DR. SOFICA

2. Why did you decide to have your procedures performed at Humble Surgical Hospital check ALL that apply.
   ✓ Recommended by physician: Dr. SOFICA
   ___ Recommended by friend or family member
   ___ Advertisements
   ___ location
   ___ Offered free initial consultation
   ___ Facility accepted my insurance company's payments as payment in full
   ___ Doctor who performed procedures at this facility offers discounts and/or incentives
   ___ Other,
   Please explain: DR. INSISTED THAT I USE THIS HOSPITAL

3. What was your main reason for having your procedures performed at Humble Surgical Hospital?
   THE DR ASK THAT I USE THAT HOSPITAL

4. Did your treating physician give you the option to have your procedure(s) performed at another facility or hospital?
   Yes ____
   No ✓
   Name of treating physician: DR SOFICA
   Comment ____

5. If your answer to Question #4 is Yes, what made your decide to use Humble Surgical Hospital instead of another facility or hospital?

6. Were you aware that Humble Surgical Hospital was a non participating facility?
   Yes ✓
   No ____
   Comments: ONLY AFTER THE SURGICAL PROCEDURE WAS SCHEDULED,

7. Were you required to pay Humble Surgical Hospital your co-insurance, deductibles and services not covered by insurance at the time of your procedure?
   A. Yes ✓; if yes, state amount you paid: $ 202.43
   B. No ____; if no, please explain.
   Comments: I WAS TOLD MY INSURANCE PAID 90% OF THE SURGERY

8. Did your treating physician provide you with any notice that he/she had any financial interest in or ownership of Humble Surgical Hospital?
   Yes ____
   No ✓
   Comments: ____

9. Please provide a copy of any documentation provided to you by Humble Surgical Hospital related to the cost and/or your out of pocket expense for your Surgical Procedure.

COPY OF REFUND FROM FLEXIABLE SPENDING ACCOUNT FOR 202.43 - ON 7/7/11

DCN: 111123089271 SEQ: 1123110049 LX

A016625

[redacted]

Account ID: [redacted]
TRANSAMMONIA, INC. (G)

0002516158
10/20/2011

192380

Claims Included In this Payment (continued)

Plan	Date Of Service	Merchant Provider	Claim Amount	Paid	Pending	Denied	Amt This Cycle
2011 HEALTH CARE FLEXIBLE SPENDING ACCOUNT	7/6/2011	llergy	$160.38	$160.38	$0.00	$0.00	$160.38
2011 HEALTH CARE FLEXIBLE SPENDING ACCOUNT	7/7/2011	hosp	$202.43	$202.43	$0.00	$0.00	$202.43
2011 HEALTH CARE FLEXIBLE SPENDING ACCOUNT	7/6/2011	stein chiro	$280.97	$280.97	$0.00	$0.00	$280.97

*** Additional claims are included in this payment** **Total: $988.78**

Current Year Account Balances

Plan	Eligible Amount	Submitted Claims	Paid	Pending	Denied	Plan Year Balance
2010 Health Care Flexible Spending Plan	$2,000.00	$1,752.00	$1,752.00	$0.00	$0.00	$248.00
2011 HEALTH CARE FLEXIBLE SPENDING ACCOUNT	$2,000.00	$1,163.78	$988.78	$0.00	$175.00	$1,011.22

The " Eligible Amount " shown is the sum of your annual election amount, plus certain credits that have been applied to your account. The " Plan Year Balance " reflects your available funds at this time. If you have questions regarding these balances or credits applied, please contact Customer Service.

Continued on next page

Aetna
SIU
PO Box 14079
Lexington, KY 40512-4079
Phone: 609-584-8518 / Fax: 860-975-1769
OBC601AA 0029 02 01 20

Category code: SIUA

11-9-2011

DCN# 111109059404

[redacted]

Member ID: W142299094

Dear Mr. [redacted]:

We are conducting a review of charges for services submitted to Aetna. Please review the submitted charges below, and verify if the services were provided as listed by indicating "Yes" or "No". We also request that you respond to the questions on the next page of this letter. We are enclosing a self-addressed stamped envelope for your convenience in returning all pages of this letter. Please sign and date your response.

Note: This inquiry is to be completed by the patient/patient's guardian/representative. Please answer to the best of your ability without consulting the doctor, clinic, hospital or billing agent.

Patient: [redacted] Provider	Service	Service Dates	Submitted Expenses	Y / N
Humble Surgical Hospital	Medical Treatment	06/15/2011 - 06/29/2011	$151,419.00	Yes ✓ No ____

Please return all pages of this letter in the enclosed envelope. If you have any questions, please contact me at 1-609-584-8518. Thank you for your cooperation.

Please have the patient sign and return the attached Authorization for release of information with this letter. The authorization will be used to obtain medical records from the provider.

Sincerely,

Garrett Shohan

Garrett Shohan
Sr. Investigator
CASE 34047

NOTICE TO ALL PARTIES COMPLETING THIS FORM: This verification is needed in support of claim submissions made to us. It is fraudulent to intentionally fill out this form with information you know to be false or to omit important facts.

A016795

DCN: 111202112391 SEQ: 1202110060 LX

DCN# 111109059404

[redacted] 11-9-2011

OBC601AA 0029 02 01B 20
Category code: SIUA

Aetna

Authorization for Release of Information

Please read and sign the following Authorization to Release Information.

To: Humble Surgical Hospital

For claim evaluation purposes, I hereby authorize the above referenced provider of medical or dental services to release to Aetna and its authorized representatives any medical, dental, or hospital records (including that related to mental illness and/or AIDS/ARC/HIV).

I also specifically authorize the redisclosure of such information by Aetna for purposes related to claim evaluation, including claim verification or review by any reinsurer or any other insurer providing coverage with respect to the claim. I understand that, except as otherwise permitted or required by law, no other use or transfer of the information may be made without first obtaining my additional written consent on a form stating the need for the proposed new use or transfer to another person or entity.

I also understand that I may revoke this authorization at any time, except to the extent that action has been taken or information released, prior to the revocation. Otherwise, this authorization shall remain valid.

I know that I (or my authorized representative) have a right to request a copy of this authorization. A photocopy of this authorization will be as valid as the original.

[redacted] 11-15-11

Patient's or Authorized Person's Signature — Date

Father

Relationship to Patient

1202116060

A016796

DCN: 111202112391 SEQ: 1202110060 LX

DCN# 111109059404

[redacted] 11-9-2011

OBC601AA 0029 02 02 20
Category code: SIUA

1. Did you receive treatment(s) on the date(s) indicated on the previous page?
Yes X
No ____; if no, please explain.
Comments There were 2 dates of service; surgery on each foot.

2. Why did you decide to have your procedures performed at Humble Surgical Hospital check ALL that apply.
X Recommended by physician: Dr. Brad Bachmann
___ Recommended by friend or family member
___ Advertisements
___ location
___ Offered free initial consultation
___ Facility accepted my insurance company's payments as payment in full
X Doctor who performed procedures at this facility offers discounts and/or incentives
___ Other.
Please explain: Dr. Bachmann told us they would bill us as In Network.

3. What was your main reason for having your procedures performed at Humble Surgical Hospital?
Dr. Bachmann prefers to use the facility and he said they would bill us using in network fees.

4. Did your treating physician give you the option to have your procedure(s) performed at another facility or hospital?
Yes X
No ____
Name of treating physician: Dr. Brad Bachmann
Comment However due to scheduling constraints, this facility had the availability; schedule driven by school schedule and recovery target.

5. If your answer to Question #4 is Yes, what made your decide to use Humble Surgical Hospital instead of another facility or hospital?
Schedule availability - We did not want our high school child to miss school or wear cast/boot to school, so recovery schedule drove surgery schedules.

6. Were you aware that Humble Surgical Hospital was a non participating facility?
Yes X
No ____
Comments: Dr. Bachman and the staff checking us in told us they would process us as if they were in network.

7. Were you required to pay Humble Surgical Hospital your co-insurance, deductibles and services not covered by insurance at the time of your procedure?
A. Yes X; if yes, state amount you paid: $ $384.86 x 2 = $769.72
B. No ___; if no, please explain.
Comments: This amount was our estimated (both feet) out of pocket co pay for the two surgeries.

8. Did your treating physician provide you with any notice that he/she had any financial interest in or ownership of Humble Surgical Hospital?
Yes ____
No X
Comments: ____

9. Please provide a copy of any documentation provided to you by Humble Surgical Hospital related to the cost and/or your out of pocket expense for your Surgical Procedure.
See attached

1202110060

A016797

DCN: 111202112391 SEQ: 1202110060 LX

DCN# 111109059404
[redacted] 11-9-2011

OBC601AA 0029 02 02B 20
Category code: SIUA

DCN: 111202112391 SEQ: 1202110060 LX